COMMONWEALTH OF VIRGINIA
Virginia Board for People with Disabilities

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TO: Connie Cochran, Assistant Commissioner
Department of Behavioral Health and Developmental Services (DBHDS)

FROM: Heidi L. Lawyer

CC: Heather Norton, Director Community Support Services, DBHDS

SUBJECT: Comments on SB 627 Matrix/Summary of Cost Analysis

As a member of the SB 627 workgroup representing the Virginia Board for People with Disabilities, I am providing comments regarding the options matrix developed and discussed over several meetings of this workgroup. As you know, this workgroup has been particularly challenging due to some polar opposite views of the scope of the legislative charge to "… consider options for expanding the number of training centers that remain open, in whole or in part, in the Commonwealth."

The Board does not support any of the four options presented to expand the number of training centers to remain open in the Commonwealth. We believe that such a decision is inconsistent with both the Supreme Court Olmstead decision and the Commonwealth's Settlement Agreement with the U.S. Department of Justice. The thoughtful and successful closure of Southside Virginia Training Center demonstrates that community services can support/serve these individuals. The Board applauds the efforts by DBHDS, the Community Service Boards and private providers to achieve that landmark closure. The Board strongly supports the closure plan outlined in the DOJ Settlement Agreement and hopes that the Commonwealth will not take a step backwards by considering maintaining or developing ICFs/IID of 16 or more beds.

The Board understands the concerns of the families and guardians of individuals who are currently served in the four remaining training centers. Change can be scary. Of note, however, is that the Training Center census has been falling for over thirty years and at present less than 600

individuals are receiving services at the Training Centers. As the census declines, per capita costs increase at the Training Centers. As noted in the DBHDS cost analysis on the SB 627 options, keeping open any other facility will require massive capital outlays as well as a long-term fiscal commitment to staffing and to facility upgrades as federal ICF/IID standards continue to evolve. Moreover, keeping more centers open results in a substantial loss of revenue from sale of surplus property, which would go into the Trust Fund.

At the same time, families have increasingly chosen to keep their loved ones with them in their communities. Over 9,000 individuals now are enrolled in the ID Waiver; almost another thousand are enrolled in the DD Waiver; and over 9,000 individuals are on the waiting lists for those waivers. These individuals, some of whom have significant medical or behavioral issues, are living successfully in their communities. In some other cases, while not the preferred scenario under the DOJ Settlement Agreement, individuals with high/intensive needs have been placed by their loved ones and are served safely and appropriately in a non-state operated ICFs/IID or a nursing home.

At the heart of the discussions at the SB 627 meetings is the meaning of "comparable services" (Factor3 in the Options Matrix). While some individuals leaving training centers may need a high level of services and supports, others will not. If a training center resident goes to an ICF/IID in a community, then he/she is entitled to the services and supports that he/she needs based on an individual assessment. Oversight by both the Virginia Department of Health Office of Licensure and Certification (VDH-OLC) and the DBHDS Office of Human Rights is provided to ensure that the services are provided. Having a doctor on-site, which may be psychologically comforting, does not ensure quality. Using contract or fee-for-service staff does not mean a lack of quality care.

Unfortunately, the workgroup was not able to examine comparability in depth. A significant oversight of the workgroup was the lack of comparison of the quality of care outcomes of community settings and the training centers, as documented by:

- ICF/IID certification/re-certification/investigations by the VDH-OLC
- Critical incident reports
- Substantiated abuse and neglect allegations and human rights complaints (severity, clinical issues)
- National Core Indicator data (those placed in community).

Comparable services are being provided successfully as evidenced by the number of individuals with ID/DD who are former training center residents now living in the community here in Virginia and in other states. The national report, *State of the States* (*2013*), points out that by 2011/12 states no longer operated large ID/DD institutions; and 14 states did not operate private large ICFs/IID. (The study defines "large" institution as a facility having 16 or more beds.) The study

notes state plans to close or closures in progress of additional large ICFs/ID over the next six years. This national trend to community services has been, and is, occurring with protections for the health, safety and quality of life of the individuals with ID/DD. Peer-reviewed studies have found that some individuals who leave institutional settings are able to function at a higher level in a smaller setting (needing less psychotropic medications, exhibiting fewer behavior challenges, and requiring less help with daily tasks such as feeding, etc.).

Over the past ten years, the DBHDS has seen a decline in requests for admissions to state training centers and has made a commitment to support individuals with ID/DD in their family home or small, more homelike settings (six beds or fewer). Obligating substantial resources on a long-term basis to support a large institution is contrary to the preferences of thousands of families. It is contrary to community inclusion and integration.

An important factor which the SB 627 workgroup failed to examine is whether the services available in the state training centers are truly appropriate and cost-effective. For example, Appendix C of the *Cost Analysis of Options* report identifies operating costs for the Northern Virginia Training Center (NVTC) under two scenarios: 75 bed capacity and 40 beds. This analysis states that NVTC would have an infirmary with 20 staff (at 75 beds) and 16 staff (at 40 beds) and a Medical Clinic with three staff (both capacities). What is the function and purpose of these services? Are these services medically necessary? Nursing Services has only two staff; are RNs counted under ICF/IID staff? Consideration of services which could be provided through the DD Health Network or private providers was not made. An ICF/IID is an ICF/IID. The fundamental question is whether the resident's level of needs warrant such a high level of on-site, full-time staffing. (Note that under both scenarios, certain operational costs seem wasteful. Administration, General and Professional Administration remain at the same level of staff (14 and 21, respectively). Similarly, seven Building & Grounds staff are listed under both scenarios.) What remains clear is that the Commonwealth must be a responsible steward of taxpayer monies while proving appropriate, needed services and supports to individuals with developmental and other disabilities.

The Board does not claim that community services are perfect. As noted in our *2014 Assessment Findings and Recommendations,* state efforts to improve the service array, especially in rural areas, still are needed. In looking at community services, the workgroup meetings gave inadequate attention to and discussion of supports such as the Regional Educational Assessment Crisis Response and Habilitation (REACH) program, the soon to be redesigned ID/DD Waiver, and the DD Health Network.

The Board supports the majority of the factors developed by the workgroup (in the Options matrix) and has the following comments relative to those:

- Factor 1. Ensures the Commonwealth provides comprehensive information to the Guardian/Resident/Authorized Representative/Family regarding all available options and resources "to prevent the unnecessary institutionalization.

- Factor 2. Provides for and maximizes the individual's health, safety and quality of life including medical, health, developmental and behavioral care, in the chosen care setting. Note: Assumption that valid outcome measures and "sentinel event monitoring" are in place and used to ensure the individual continues to receive appropriate care.

The Board believes that Factors 1 and 2 are being met and will continue to be met by serving individuals with ID/DD in community settings. DBHDS has developed a discharge process to ensure that appropriate services and supports are in place for each individual.

- Factor 6. Provides reasonable geographic proximity to families, services and supports for individuals who elect to continue care in a Training Center or in the community; and if a facility is chosen, it is integrated into the greater surrounding community—providing access to the greater community similar to individuals who live in settings viewed as more integrated.

The Board agrees that geographic proximity is an important in sustaining family bonds. Waiver homes, non-state operated ICFs/IID, and sponsored residential placements in each locality served by the training centers exist throughout the Commonwealth and as capacity increases, so will geographic accessibility. It is only if a family chooses continued Training Center placement that geographic proximity becomes an issue; and the decision of a small number of families should not be the rationale for maintaining the current number of training centers or discontinuing the current plan to close the remaining three (excluding SEVTC) Training Centers by 2020.

- Factor 4. Increases, decreases or has no impact on the cost of serving individuals in a <"right-sized"> Training Center versus the cost of providing comparable care to those served in the community. If the costs of Training Center care is more expensive, would there be a negative impact on access to services for those being served in the community?

- Factor 5. Recognizing that the current system is under-funded, maximizes efficiency and either realizes savings or limits the financial impact on the Commonwealth; such that the overall affordability of the care system is maintained or improved. The processes of permitting, securing capital and financing capital improvements to existing Training Centers or other residential options do not strain current staff and financial resources—negatively impacting other care system priorities. Note: Any savings realized should be reinvested in the overall care system.

Factors 4 and 5 are critical to the decision-making process. The fiscal impact of maintaining training centers or building new smaller institutions is significant. As noted in the report, rebuilding

of the four remaining facilities is a huge financial commitment. In addition, over time capital outlay, staffing and other operational costs of the training centers will increase due to evolving federal standards of care. While the rebuilding is a major one-time cost, maintaining the facilities will be a long-term expenditure. Once rebuilt, even as admission requests decline, the smaller facilities will divert funds which could be used to support those currently receiving services under a home and community based waiver or support some of the 9,000+ individuals waiting for a waiver slot.

The Board recognizes that a system change to community care is challenging for all stakeholders. Whether or not to maintain large state operated institutions ultimately is a decision of the legislature. The Board recommends continuing the plan as outlined in the DOJ Settlement Agreement to close its state operated training centers and to continue its work towards building a community service system that can serve all of its citizens with ID/DD.

Thank you for this opportunity to provide comments.